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'Believe it or not': the medical framing of rectal foreign bodies

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ABSTRACT

Medical and lay attention to and intervention for rectal foreign bodies, the presence of an object in the rectum most often via insertion through the anus, has long been a source of humour and suspicion in both medical and public discourses. How do the ways medical providers write and talk to each other about rectal foreign bodies shape and reflect understandings of gender, sexuality and the (im)proper use of the anus and rectum? This paper examines the medical literature on rectal foreign bodies to shed light on the ways in which medical providers frame rectal foreign bodies. It develops a set of six frames that demonstrate how the medical literature on rectal foreign bodies (re)produces a variety of normative assumptions about and sociocultural values concerning bodies and sexuality, danger, shame, deception, mental illness and medical professionalism. It concludes with a discussion of how these framings of rectal foreign bodies might potentially contribute to the ongoing stigmatisation not only of rectal foreign body patients, but of non-heteronormative sexualities in general.

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Introduction

In the November 1939 issue of *California and Western Medicine*, Dudley Smith, MD, provided a case report and an accompanying photograph of an object removed from the rectum of a 59-year-old man. The clinical notes begin: 'The accompanying photograph, "believe it or not," shows an extraordinary foreign body removed from the rectum' (Smith 1939, 329). The case report includes an account of the patient's explanation for visiting the physician: '[the patient] stated he was using the instrument "*to massage the prostate*"; and as he stepped out of the bathtub he fell on the edge of the tub, forcing the entire gadget into the rectum' (329, emphasis in original). The 'gadget' is described as a hose that was cut and tapered on one end over which a yellow balloon, emblazoned with an image of the Golden Gate Bridge, was bounded with cord. The case report explains that Dr Smith was consulted eight hours after the insertion of the 'gadget,' which was easily removed using only a Kocher haemostat and his fingers. Despite being inserted 14 inches (35.5 centimetres) deep, Dr Smith found no internal perforation, which he attributed to the presence of water in the balloon. He concluded the report: 'This is, no doubt, the first time the Golden Gate Bridge has been pulled out of the rectum!' (329).

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Rectal foreign bodies, the presence of an object in the rectum commonly via insertion through the anus, have long been a source of fascination, humour and suspicion in both medical and public discourses. Yet, there are increasing calls for sensitivity and professionalism among providers who encounter rectal foreign bodies in the clinic. How do the ways medical providers write and talk to each other about rectal foreign bodies shape and reflect biomedical understandings of gender, sexuality and the (im)proper use of the anus and rectum? How do these discourses shed light on reasoning and judgments about what objects are (in)appropriate for insertion into various part(s) of the body? How might these discourses contribute to, rather than alleviate, the problem of postponed care-seeking for rectal foreign bodies? And in what ways are medical providers complicit in reinforcing heteronormative[1] assumptions about sexualised bodily practices through their framing of rectal foreign bodies?

In this paper, I aim to illuminate some of the sociocultural assumptions at work in the medical literature on rectal foreign bodies by examining the ways medical providers – mostly physicians – frame rectal foreign bodies in medical literature. Drawing on the social science literature on the social construction of disease (Aronowitz 2008; Rosenberg 1997), I argue the subtle heteronormative assumptions and distrust for patients in the medical literature concerning rectal foreign bodies is infused with culturally-derived beliefs about bodies, genders and sexualities. The article begins by explaining the theoretical and methodological approaches used to interpret the medical literature concerning rectal foreign bodies. It then outlines a set of six themes, with supporting examples from the medical literature, that demonstrate how the framing of rectal foreign bodies (re)produces a variety of normative assumptions about gender and sexuality, danger, shame, deception, mental illness and medical professionalism.

Background

Biomedicine is often thought to be an objective and culture-free enterprise (Taylor 2003). Yet medical literature, as with any body of scientific literature, is never value-neutral or free of ideology (Habermas 1970), and not only conforms to but also (re)produces and instils cultural norms (Martin 1991; Upchurch and Fojtova 2009; Wilce 2009). Whether intentional or not, the ways medical providers communicate shapes understandings of illness, sickness and disease in particular ways, often subtly reinforcing moral norms in the process and thus helping to control social behaviour (Waitzkin 1989). This is true of gender and sexual norms. Biomedical environments routinely reproduce heteronormativity both through the medical education and training process (Murphy 2014; Obedin-Maliver et al. 2011; Robertson forthcoming; Sörensdotter and Siwe 2016) as well as through clinical environments and cultures (Baker and Beagan 2014; Beehler 2001; Harbin, Beagan, and Goldberg 2012). Another source of the (re) production of heteronormativity in biomedicine is the way medical issues get framed.

Robert Aronowitz (2008) refers to the recognising, naming, categorising, defining and attributing causal forces to diseases as *framing*, and he argues that it 'can have profound effects by influencing individual and group behaviour, clinical and public health practices, and societal responses to health problems' (2).[2] The ways healthcare providers and researchers frame disease, in other words, is not straightforwardly descriptive, but also constitutive in that the cultural and moral meanings and values attached to diseases actually shape the experiences, expressions and courses of disease, illness and sickness.

While much of the literature on medical discourse concerns provider-patient interactions in biomedical settings, attention to the norms embedded in other medical contexts, such as medical literature, are also important to consider (Wilce 2009, 201). The analysis in this paper focuses on a specific genre, the scientific medical article, as a key resource for engaging in a critical examination of medical discourses that help shape and reinforce cultural norms. Medical papers are a form of scientific literature that take a standard format depending on whether they are case reports or research. Case reports are typically divided into three sections: Introduction, Case Report and Discussion. Research reports are usually divided into the 'Introduction, Methods, Results, Discussion' format common to other bodies of scientific literature. Each section serves a specific purpose and has some typical kinds of information: the introduction contains background information, including citations of related literature that help establish a context for the research; the methods section includes information on how data was collected and analysed; the results section provides the outcomes of the data analysis; and the discussion section explains the results in light of the background context, sometimes including a discussion of how the research contributes to the literature (Nwogu 1997). The introduction and discussion sections of medical research articles are where the most obvious sociocultural framing occurs.

Methods

The data examined here come from biomedical journals. I conducted literature searches on PubMed, BioMedCentral, BIOSIS and PsychINFO using the terms 'rectal foreign body/bodies', 'anorectal foreign bodies' and 'colorectal foreign body/bodies'. Sources were excluded if they were duplicates from previous searches, contained only descriptions of medical procedures directly or indirectly related to removal of rectal foreign bodies without commenting on the phenomenon, discussed only ingested rectal foreign bodies or were written in languages other than English. This resulted in a total sample size of 147 sources.

Data analysis consisted of coding the sources using both *a priori* codes (e.g. heteronormativity, humour, etiological explanations, delayed treatment, professionalism) and emergent codes (e.g. deception, mental illness, danger) to extract examples of framing. Examples were then grouped together based on my interpretation of them as more or less related, resulting in the six themes discussed below.

General claims in the rectal foreign bodies literature

The framing of rectal foreign bodies regularly begins by stating they are an old and 'well-described' phenomenon, sometimes noting that textual descriptions go back to the sixteenth century. Citing an article by Haft and Benjamin (1973) on the psychosexual aspects of rectal foreign bodies, many articles claim the earliest examples of rectal foreign bodies date back to Ancient Greece or Ancient Egypt. The earliest known case report in a medical journal was published in 1919 (Smiley 1919), though there are discussions of rectal foreign bodies in early proctological literature, specifically in medical textbooks (e.g. Gant 1902[3]) and surgical treatises (e.g. Poulet 1881). The number of rectal foreign body articles has increased over time, from less than 30 articles appearing in literature before the 1950s to 66 articles from 2000 to 2015.[4]

The most recent literature conflictingly describes rectal foreign bodies as both rare and common. The actual incidence of rectal foreign bodies is unknown. Though many articles

note it is an increasingly common occurrence in emergency and colorectal surgery clinics, it is difficult to tell if this claim is an artefact of increased availability of information, increased reporting or an actual increase in the number of cases. The fact that there is no epidemiological data on rectal foreign bodies is important to keep in mind when considering the statistical and demographic claims framing rectal foreign bodies. The literature makes the following assertions about the demographics of rectal foreign body patients: they are most likely to be men in their 30s to 50s, with reported male-to-female ratios from as low as 4.3:1 (Odagiri et al. 2015) to as high as 28:1 (Busch and Starling 1986). Patient race or ethnicity is rarely mentioned. Very few articles mention the sexual identity of patients; among those that do, there is ample evidence that rectal foreign bodies are not limited to any sexual orientation despite the continuing uncritical citation of literature from the 1970s through the 1990s making unfounded claims about rectal foreign bodies being predominantly a homosexual problem (e.g. Barone, Yee, and Nealon 1983; Crass et al. 1981; Kouraklis et al. 1997). This issue is discussed later.

The most common objects reported in the literature are household items. Bottles and glasses accounted for 42.2% of rectal foreign bodies in one systematic literature analysis (Kurer et al. 2009); other reported items include aerosol cans, light bulbs, broomsticks, vacuum parts, flashlights, tools and construction materials (e.g. nails), animals (e.g. an eel), food items (mainly fruit and vegetables), sex toys and packets of drugs (from smuggling). The most common reasons for insertion provided by the medical literature are pleasure/auto-eroticism, mental illness, concealment/smuggling/criminal activity, accident, assault/forced insertion, attention-seeking and alleviation of anocolorectal health problems such as haemorrhoids and constipation. Most patients sought care within 24 hours of insertion, but there are reports of people waiting days or weeks before seeking care. The longest delay in treatment located in the literature was five years after insertion (Ozbilgina et al. 2015). Radiographs are ubiquitous and more common than photographs of removed objects or surgical procedures. Such images, especially radiographs, contribute to the spectacle of rectal foreign bodies because they visualise the objects in ways that allow the reader to imagine and react to the phenomenon in a manner textual clinical description alone does not.

Themes in the literature

It was possible to identify six themes from the medical literature ($n = 147$) that are indicative of common patterns in the medical framing of rectal foreign bodies: (1) gender and sexual norms; (2) danger; (3) shame, embarrassment and delay; (4) deception; (5) mental illness; and (6) professionalism and sensitivity (see Table 1 for number of articles that illustrate each theme).[5] Below I describe each frame and provide specific examples from the literature.

Table 1. Number of articles ($n = 147$) illustrating each framing.

		Number of articles(%)
Frame 1	Gender and sexual norms	102 (69)
Frame 2	Danger	66 (45)
Frame 3	Shame, embarrassment and delay	49 (33)
Frame 4	Deception	55 (37)
Frame 5	Mental illness	46 (31)
Frame 6	Professionalism and sensitivity	24 (16)

Gender and sexual norms

The medical literature frequently (see Table 1) frames rectal foreign bodies as a gendered problem, emphasising the higher prevalence in men than women. The male-to-female ratios provided by the literature vary across time and place, often repeating numbers from earlier studies uncritically. None of the medical literature included in this analysis explicitly speculates as to why this higher prevalence may occur, but the spectre of homosexuality is regularly present. Many articles frame rectal foreign bodies as being linked to 'perverse', 'deviant' or otherwise non-normative gender behaviours and sexualities. For example, Yacobi, Tsivian and Sidi (2007) claim that 'atypical gender behaviour (e.g. transvestitism) [was] among the factors that raised suspicion for rectal FB' (1524). Similarly, Wigle (1987) argued, '24 hours of postremoval observation has been considered mandatory. Recently, two series from major cities with large homosexual populations have suggested otherwise. In one, 21 of 36 patients were able to have the foreign bodies removed successfully in the emergency department' (387). The mention of 'homosexual populations' has no relevance to the overall point being made, but it has the subtle effect of linking rectal foreign bodies to homosexuality without explicitly drawing a connection since generalising about the sexual orientation of male rectal foreign body patients is not possible due to a lack of information in the literature (Ahmed and Cummings 1999; Busch and Starling 1986; Khan et al. 2008).

The authors of one Spanish study did provide information about patient sexualities, noting that only 5 out of 30 total rectal foreign bodies patients identified as homosexual men (Rodriguez-Hermosa et al. 2006). In the introduction to the paper, the authors explicitly link rectal foreign bodies to several non-normative subject positions and practices: 'the transanal introduction of [foreign bodies] can be observed in penitentiary prisoners, psychiatric patients, homicide and suicide attempts, erotic acts, homosexuals, sadomasochistic practice, cases of sexual aggression or rape, people under the effects of drugs or alcohol and drug carriers' (543). Later in the article, the authors continue: 'associated factors [of rectal foreign bodies] included mental disorders in 11 [patients], false teeth or dental correctors in seven [due to ingestion], *homosexuality in five*, penitentiary confinement in two, and drug and alcohol intake in two' (Rodriguez-Hermosa et al. 2006, 544, emphasis added). Interestingly, 'heterosexuals' are not listed as a group in which rectal foreign bodies can be observed even though only 5 out of 30 (17%) patients were identified as homosexual. Heterosexuality is not provided as an associated factor, but a more accurate description would be 'associated factors include heterosexuality in 25 patients.' The framing of this as a homosexual problem obscures the fact that, at least in this Spanish cohort, homosexuals in fact made up a minority of cases, yet are nonetheless emphasised as a problem group.

A final heteronormative framing is the implication of what particular body parts are for, positing certain body parts – the vagina and anus – as being more or less appropriate for insertion. Authors commonly referred to inserted objects as 'phallic' in shape and size. Anderson and Dean (2011), for example, note 'objects inserted for sexual stimulation are typically blunt, and often resemble a penis in size and shape' (382), which invokes the heteronormative assumption that penises are for insertion. Busch and Starling (1986) argue, 'foreign body insertion into women is often by the vaginal route, which would appear to offer advantages over the rectal route in control, comfort, distensibility, sensation, strength, and lubricity' (512). These framings reinforce the heteronormative taboo on anal insertion by naturalising the female genitals as being *for* insertion whereas the anus is not. This framing is linked to the dangers anal insertion can pose to one's health.

Danger

The literature is inconsistent in framing rectal foreign bodies as more or less dangerous, though claiming some level of danger is common (see Table 1). Kasotakis, Roediger and Mittal (2012) state, 'numerous types of objects have been described in the literature and all of them should be regarded as potentially hazardous of causing significant injury' (112). Yacobi, Tsivian and Sidi (2007) go even further, arguing 'the *extreme lengths* some individuals are willing to go to provide themselves and their partners with *erotic highs* has led to the need for large numbers of *extraordinary therapeutic measures*, both medical and surgical' (1528, emphasis added). These authors describe rectal foreign bodies as resulting from an 'extreme' search for getting high, which has produced a need for new and innovative kinds of medical and surgical interventions. Yet, just a few pages earlier in the same article, the authors note that rectal foreign bodies 'most often do not cause significant anorectal injuries, but complications can arise either from their insertion or removal' (1524). Similarly, Lake et al. (2004) report 'most objects can be safely removed at the bedside' (1694). Others echoed these points as well, and these mixed messages may be indicative of a bias in the medical literature on rectal foreign bodies resulting from an overemphasis on cases with complications. The framing of rectal foreign bodies as dangerous, either due to the objects that are inserted or the bodily location of insertion, is erratic because authors differ on the amount of danger they wish to emphasise. The general tone, however, is that rectal foreign bodies are dangerous because they may result in health complications.

Shame, embarrassment and delay

Rectal foreign bodies are sometimes framed as embarrassing (see Table 1), and this shame is linked to delays in treatment seeking as well as deception on the part of patients (discussed later). For example, Anderson and Dean (2011) argue 'an accurate history may be impeded *by the patient's embarrassment*' (382, emphasis added). The authors do not mention the source of the patient's embarrassment – what is the role of the medical provider in producing rather than simply observing this embarrassment? The literature fails to consider sociocultural reasons behind such shame and embarrassment, presenting it as an uncomplicated element of rectal foreign bodies or as a 'natural' result of the clinical situation. Only one article comes close to acknowledging the role of medical providers in (re)producing this taboo. Khan et al. (2008) note 'the motivation [behind rectal foreign bodies] is often assumed to be sexual but *is rarely discussed in practice*, probably due to the sensitivity of the situation and the potential embarrassment for patient *and clinician* alike' (246, emphasis added). This was the only example I located in the medical literature that explicitly noted the role of clinician embarrassment; all the other literature framed embarrassment as a patient problem.

In cases where embarrassment and shame were discussed, the authors linked them to delays in treatment-seeking behaviour. Desai (2011) argued that 'patients may be too embarrassed to present early to an Emergency Department' (2), and Pinto et al. (2014) noted that 'the diagnosis and management of rectal foreign bodies can be difficult because of shame or embarrassment felt by the patients, which often leads to delayed presentation' (89–90). Anderson and Dean (2011) argued that patient embarrassment 'is also responsible for delays in presentation', and they continued that 'fabricated histories are not uncommon' (382). The link between shame/embarrassment and delayed treatment-seeking is also implicated in the framing of patients as deceptive in their presentations in medical environments.

Deception

Many of the articles (see Table 1) present a similar story of deception: a man walks into an emergency clinic, gives 'vague complaints of abdominal pain and constipation' (Desai 2011, 1), denies the presence of any rectal foreign bodies and upon its discovery via examination or X-ray, begins to 'formulate unusual stories to explain how the object became lodged in the rectum' (Pinto et al. 2014, 91). Patients are commonly described as deceptive and distrustful in many ways, including emphasising their deviant nature and excuse-making in the face of the supposedly undeniable truth of radiograph images.

One of the common tropes in this framing is the dismissal of accidental insertion. Kurer et al. (2009), for example, claim that accidental insertion seems unlikely based on the descriptions in the medical literature they reviewed. But this begs the question of what patients mean by 'accident'? As far as I can tell, providers regularly assumed they understood what patients meant by claiming accidental retention of inserted rectal foreign bodies. There were no instances of providers explaining their inquiries with patients regarding what they meant by their situation being an accident, sometimes enclosing the word 'accident' in quotation marks in to emphasise scepticism about such claims. One interesting exception to this framing comes from a review of 93 cases of anally-introduced rectal foreign bodies at Los Angeles County + University of Southern California General Hospital, where the researchers found the vast majority (98.9%) of patients presented with complaint of rectal foreign bodies: 'This is in contrast to previously reported studies in which patients often presented with obscure anal or abdominal pain, denying rectal introduction of a foreign body' (Lake et al. 2004, 1696).

Even in cases when patients do not claim accidental retention but instead explain they were attempting to relieve some symptom or discomfort, authors sometimes dismiss this as an unlikely story invented 'by means of coping with the embarrassment of the interview without implicating an innocent person' (Busch and Starling 1986, 515). This frames the insertion of objects into the anus/rectum to relieve such health issues as an inherently deceptive rather than a potentially honest answer. Thus, it appears any answer other than 'I was pleasuring myself and inserted the object too far' is approached with suspicion on the part of providers. This suspicion of patients is often accompanied by providers recommending patients for psychiatric evaluation.

Mental illness

Rectal foreign bodies are also linked to mental illness (see Table 1). Often when patients insisted they did not know how an object ended up in their rectum, providers would refer them to counselling or psychiatric services, which was nearly always declined by patients. Ahmed and Cummings (1999) recommend psychosocial counselling for rectal foreign body patients by remarking that many turned out to have mental health issues including depression, social stress and, in one case, schizophrenia. This frames rectal foreign bodies as connected to mental illness in a vague enough way to be interpreted by the reader through whatever lens they may be using to view rectal foreign bodies and mental illness, both typically stigmatised health issues.

In most cases reported in the literature, rectal foreign bodies do not appear to be a mental health issue. Still, many providers recommend referring all rectal foreign body patients for counselling or psychiatric evaluation. Busch and Starling (1986) recommend 'sexual

counselling for all patients admitted with colorectal foreign bodies' to determine 'whether the patient suffers from a treatable psychiatric disorder' (515) in addition to avoiding recurrence of rectal foreign bodies and minimising trauma because of assault. Coskun et al. (2013) conclude their case report, which contained no discussion of mental illness elsewhere, by saying 'patient was referred to the psychiatrist for his perversion disorder, which was also mandatory for preventing recurrences' (5), and Elias et al. (2014) frame rectal foreign bodies as 'a result of pathological sexual activities' (1).

Humes and Lobo (2005) and Khan et al. (2008) link the presentation of rectal foreign bodies in some patients to Munchausen syndrome, a psychiatric disorder where people fake some disease or trauma for attention- or sympathy-seeking reasons. Whereas in Khan et al. (2008) case the suspicion of Munchausen syndrome came out of the patient's consultation with a psychiatrist, for Humes and Lobo (2005) there is no discussion of a psychiatric consultation and instead the suspicion of Munchausen syndrome is based on a lack of perianal trauma in the patient, who claimed his rectal foreign body was the result of sexual assault. While sexual assault is indicated as a potential cause of rectal foreign bodies in the literature, the cases above demonstrate that sometimes providers place more faith in their examination than a patient's words. Cologne and Ault (2012) argue that the potential for underlying psychiatric disorder or possibility of assault requires the provider 'to maintain the utmost degree of professionalism' by being 'nonthreatening and nonjudgmental' (214).

Professionalism and sensitivity

The least common, though arguably most necessary, frame is an explicit call for professionalism and sensitivity concerning rectal foreign body patients (see Table 1). Most of these appeals for professionalism are accompanied by a warning that humiliation and insensitivity are linked to delays in treatment-seeking as well as increased risk of complications – the importance of rapid intervention is regularly emphasised. The potential for assault was frequently invoked as an important reason for providers to be sensitive to patients. Yet, there were also examples of providers claiming that patients made up stories about being assaulted due to feelings of embarrassment; in some cases, those claims were substantiated but in others they were merely speculations on the part of the author.

The importance of professionalism is also connected to helping obtain accurate information during the taking of patient histories. Pinto et al. (2014) note that: 'it is important that patient privacy be duly respected and staff members should refrain from making negative or comical remarks concerning the nature of the problem' (91). Busch and Starling (1986) argue that:

> no purpose is served by humiliating the distressed patient. Embarrassment and fear of humiliation may explain frequent reports of patients admitted with rectal foreign bodies who give vague and nonspecific histories, often resulting in delayed diagnosis and treatment and an increased risk of complications. (516)

Framing and the production of taboo

The serious risks posed by rectal foreign bodies are regularly emphasised by highlighting the dangers involved in their retention and extraction. Appeals to professionalism and treating patients sensitively sometimes accompany discussion of these risks, but there are

examples of medical providers betraying these tenets in their communications with the public, for example in books that sensationalise and joke about rectal foreign bodies (e.g. Dreben, Knight, and Sindhian 2011; Gaizo 2013). There appears to be a disconnect between, on the one hand, the medical framing of rectal foreign bodies as a serious problem requiring immediate intervention while maintaining strict professionalism and, on the other hand, the ways physicians communicate about rectal foreign bodies to the lay population through popular media. The pleas for sensitivity and professionalism in the medical literature are failing to be translated into popular discourse.

The framing of sensitivity towards patients is sometimes explicitly linked to involuntary aetiologies but not to eroticism. The effect of this framing is emphasising sensitivity not because patients are in pain or need medical help, but because the situation may not be self-inflicted or may arise out of mental illness. Apparently, sane and rational people do not engage in anal eroticism or voluntarily put things 'up there'. Assumptions about the irrationality of rectal foreign body patients is rampant and uncritically espoused, for example: 'many case histories have been written of patients who had introduced a foreign body into the rectum. Most of these histories confine themselves to a short description, without elaborating on the reasons behind this kind of *irrational behaviour*' (Jansen 1969, 174, emphasis added). The framing of rectal foreign bodies as vaguely associated with mental illness raises the question: if every patient was referred for psychosocial counselling, how many cases of serious depression, stress and schizophrenia would be found, and would these problems be so easily linked to a cold or urinary tract infection as they are to rectal foreign bodies? I am not arguing here that there are never any mental health issues in patients with rectal foreign bodies or that they are never the result of mental illness; however, the literature tends to avoid a nuanced view of any links between mental illness and rectal foreign bodies.

While some of the medical literature encourages providers to behave sensitively and professionally in clinical settings, I located no examples of providers discouraging one another from engaging in public displays of shaming rectal foreign body patients. How can rectal foreign body patients feel comfortable being open and honest in clinical settings given the widespread disdain towards and stigmatising of rectal foreign bodies in popular discourses, which likely have a symbiotic relationship with the medical literature on rectal foreign bodies *vis-à-vis* provider discourses and practices in clinical settings?[6] If providers wish to diminish the problem of delayed treatment-seeking, they must cease reproducing the taboo on anal pleasure rather than using it to frame medical knowledge about rectal foreign bodies.

The literature as a whole does not take seriously the issue of sexual subjectivity. For example, Rodriguez-Hermosa et al. (2006) argue that rectal foreign bodies are 'observed in penitentiary prisoners, psychiatric patients, homicide and suicide attempts, erotic acts, homosexuals, sadomasochistic practice' (543), which frames rectal foreign bodies as an act of deviance devoid of any positive sexual subjectivity. Why not frame rectal foreign bodies as regularly occurring as part of healthy consensual sexual practices among people of many genders and sexual orientations? Providers should begin encouraging open communication and education about how to safely engage in anal stimulation with objects that pose the lowest risk of retention or damage. There are very few examples of articles that recommend this kind of intervention, though it was suggested as early as the mid-1980s (Busch and Starling 1986; but see also Ahmed and Cummings 1999; Cheung et al. 2007). Andrabi et al.

(2009) argue that because of the 'increasing incidence' of rectal foreign bodies – again, something that cannot be substantiated due to lack of epidemiological data – every surgeon 'should be familiar with both surgical and non-surgical management options' (404). Even articles that do an excellent job of encouraging discussion about harm reduction strategies can still fall into the trap of using these kinds of framings (e.g. Unruh et al. 2012), which is indicative of their perniciousness.[7]

There is a culture of shame surrounding anal pleasure, and healthcare providers themselves contribute to this stigmatisation through the ways they frame rectal foreign bodies as a problem of deviance, deception and abnormality. Interestingly, and frustratingly, they engage in these framings while simultaneously calling for the sensitive treatment of patients through the maintenance of medical professionalism. Even though they recognise the problem of hesitation and delay in seeking treatment for rectal foreign bodies, they fail to recognise how their own systems of knowledge production contribute to such problems. When healthcare providers regularly frame rectal foreign bodies in these stigmatised ways, it is hardly surprising people avoid seeking care.

It is important to emphasise that the problem of delayed treatment-seeking for rectal foreign bodies is larger than embarrassment caused by interactions with healthcare providers. The medical literature does not consider this embarrassment to arise from a complicated and deeply-ingrained taboo around the anus, but rather shame and embarrassment are framed as a natural and self-evident outcome of the clinical presentation. Patient hesitancy to disclose the presence of rectal foreign bodies immediately upon examination likely does arise out of embarrassment, but such embarrassment arises out of social relations rather than as a natural fact of anal insertion and pleasure. The medical literature both explicitly and implicitly frames anal stimulation and pleasure as unnatural, thus reinforcing heteronormative ideas about what the anus is (not) for. Under this heteronormative logic, the vagina is 'meant for' pleasurable penetration, but no one's anus is 'meant for' pleasuring through insertion (Agnew 1986). The act of intentionally pleasuring the anus transgresses the socially-inscribed boundary between normative masculine sexuality and normative feminine sexuality. When male bodies engage in so-considered female (read: receptive) acts, they are viewed as queer, and thus the anus comes to be thought of as a queer bodily organ, a site where the dividing lines between masculinity and femininity break down (Bersani 1987; Hocquenghem [1972] 1993; Morin 2010; Treichler 1987). The anus, a sexually liminal yet genderless organ, is viewed as a proxy-vagina on the male body (Freud 2000, 18). Even women who engage in the act of receptive anal sex can come to think of it as a queer act (Epstein 2010, 78). To that extent, the anus may also be considered a queer organ when it is employed in non-reproductive heterosexual acts.

There is, though, another matter of the anus that cannot be overlooked. The association of the anus with waste elimination is often considered the source of the revulsion at the base of the anal taboo; yet, as Freud (2000) notes, the genitals are also sites of waste elimination but lack the immense level of revulsion attached to the anus. There are at least two points to consider here. First, there is the pervasive grounding of sexuality in the genitals (rather than thinking of the entire body as a sexual organ). The ascription of sexuality to genitals inscribes them with a purpose – they are 'for' sex, and thus other organs, including mouths, hands and anuses, are 'not for' sex. This is evident in the various kinds of social anxieties around non-procreative, non-heteronormative sexual acts. For the anus in particular, this taboo is buttressed with the authority of biomedicine, which rather than educating patients or the public about how to safely engage in anal eroticism, 'has had little to say

except, "Don't do it!'" (Morin 2010, 17) based on perceptions of risk for all kinds of health issues, including the transmission of diseases spread through faecal transmission.

Second, there are differences in the kinds of symbolism that bodily excretions are imbued with – blood, milk, semen, urine and faeces are all ascribed different meanings in different contexts. Faeces and urine are usually considered 'waste', whereas blood (except, perhaps, menstrual blood), milk and semen are considered life-giving. An example of the fraught symbolism of faeces and urine can be seen in the practice of *la rôtie*, a ceremonial practice in rural France where unmarried youths invade the room of a newly-married couple to present them with a chamber pot containing champagne and chocolate, explicitly noted to represent urine and faeces through humorous jokes about appearance and taste, which is then consumed by all present. *La rôtie* is a parodic ritual of subversion wrapped up in symbolic systems related to family, farming and especially social class as it is meant to contradict the cosmopolitan French upper-class notions of the 'legitimate art of living' (Reed-Danahay 1996, 751). While *la rôtie* is a rather joyous example of how 'bodily waste' works as a symbol of celebration and resistance, there is an omnipresent association of faeces – and by proxy the anus – with disease and death.

Rectal foreign bodies are framed in these ways not because medical or public health research on rectal foreign bodies has demonstrated such dangers – again, there is no epidemiological literature on the topic. Rather, they are framed in these ways because physicians and nurses are embedded within a set of cultural beliefs and practices that inform not only clinical encounters but also the very production of knowledge about rectal foreign bodies. There is no objective view of rectal foreign bodies based on epidemiological or other statistical data. The framing of rectal foreign bodies in the medical literature is always already prejudiced by the anal taboo.

Conclusion

The analysis presented here, like the knowledge produced in the medical literature itself, is undoubtedly restricted by the dearth of research on rectal foreign bodies and anal pleasure and health. The lack of critical research is an unsurprising result of the anal taboo. Disease framings circulate among medical knowledge producers, practitioners and the public and, in the process, they bring into effect a politics of illness, disease and sickness that (re)produces gender and sexuality norms.

Future empirical research on this topic could include qualitative data collection that takes seriously the motivations and experiences of rectal foreign bodies patients. Patient voices are absent from the medical literature, and physician and nurse voices come to stand in for patients much too easily, impugning the motivations of patients by substituting socially-derived assumptions for actual data on patient motivations and experiences. Such research could help illuminate the phenomenon of rectal foreign bodies from patient perspectives, which could in turn improve the approaches healthcare providers use for treating rectal foreign bodies. Furthermore, qualitative data could be collected on provider perspectives on rectal foreign bodies to get a better sense of their views outside of the professionalised medical literature.

Ultimately, the way medical providers frame medical problems affects patient behaviour and public understandings of various health issues. The medical framing of disease, illness and sickness is never simply descriptive; rather, it actually constructs such phenomena in meaningful ways that are taken up, reproduced and influence experience. Too often, these

framings smuggle in sociocultural norms and morals under the guise of medical objectivity. Improving health outcomes requires providers recognise how they contribute to the framing of health problems as social, cultural and moral issues.

Notes

1. I use the term 'heteronormative' to refer to the implicit view of cisgender (i.e. non-transgender) reproductive heterosexuality as natural and normal to the extent that it is the assumed default subject position. For more on this topic, see Rich (1980), Warner (1993), Katz ([1995] 2007), Sullivan (2003), Boellstorff (2004) and Dean (2014).
2. The type of 'framing' used here is not the same as the concept is used in linguistics. Aronowitz developed the concept of framing as a way to avoid the baggage attached to 'social construction of disease', which he argues can include 'a style of dated cultural relativism, a lack of common sense, and a reflexive opposition to biomedicine' (Aronowitz 2008, 2).
3. Interestingly, the chapter on foreign bodies in this early proctology textbook, which includes a discussion about rectal foreign bodies inserted through the anus, appears just before the chapter titled, 'Sodomy (Pederasty) and Rectal Onanism (Rectal Masturbation)'.
4. An in-depth discussion of trends in this literature must be taken up in a future publication.
5. Except for the 'danger' framing, which has remained steady over time, all frames are increasing in frequency over time.
6. Due to limitations of space, this issue of public discourses of rectal foreign bodies must be taken up elsewhere.
7. I thank the anonymous reviewer for bringing this article to my attention and also pointing out the embeddedness of these kinds of framings even in literature meant to reduce their prevalence.

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